

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09749

9785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Md.</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Delaware</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> d. STREET ADDRESS <u>1430 W. 2nd St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Macla</u> Last <u>Bacon</u>				4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1960</u>													
5. SEX <u>2</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 28 - 1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>				11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Smuts</u>						14. MOTHER'S MAIDEN NAME <u>Maggie Benson</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>						17. INFORMANT <u>Mary Maggachon</u> Address <u>Pocomoke Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary obstruction (probably)</u> DUE TO <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Much over weight</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>8/20/60</u>					
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cottage Grove cemetery</u>				22d. LOCATION (City, town, or county) <u>Worcester Md</u>				(State) <u>228</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Sartorius</u>						24a. RECEIVED BY REGISTRAR <u>401 Somerset City</u>				24b. REGISTRAR'S SIGNATURE <u>William H. Sartorius</u>							
DATE <u>AUG 29 '60</u>																	

TO DETERMINE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9788

CERTIFICATE OF DEATH

Reg. Dist. No.

09750

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
c. LENGTH OF STAY IN 1b <u>91 yrs</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Sidney</u> Last <u>Burroughs</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 - 1869</u>	9. AGE (In years last birthday) <u>91 1/2</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY IN BIRTHPLACE (State or foreign country) <u>own farm</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
11. FATHER'S NAME <u>James Burroughs</u>				14. MOTHER'S MAIDEN NAME <u>Annie Bunnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs Viola H Burroughs</u>				Address <u>Snow Hill, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIAC FAILURE</u> DUE TO (c) <u>CACINEXIA & INANITION & ANEMIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Hrs</u> <u>1 MONTH</u> <u>3 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUN. 1, 1960</u> , to <u>AUG 13, 1960</u> , that I last saw the deceased alive on <u>AUG 11, 1960</u> and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.				ADDRESS (Street, city or town, state) <u>106 Bay St Snow Hill, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>				DATE SIGNED <u>8-13-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 15/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Worcester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. James</u>				24. REC'D BY REGISTRAR <u>AUG 16 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

(M)

X

(I)

(D)

(1)

(BP)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1

Robert C. La Motte, M.D.

2200 Hill, Maryland

100 May St

8-13-60

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9780

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film G269 8-24-60 et

09751

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b <u>3 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Office 45 Somerset St</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> d. STREET ADDRESS <u>1013 FIFER Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Edwin Castle</u> First Middle Last 4. DATE OF DEATH <u>Aug 13 1960</u> Month Day Year			5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 17 1911</u> Month Day Year		
9. AGE (in years last birthday) <u>49</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u> 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Conn Castle</u> 14. MOTHER'S MAIDEN NAME <u>Beulah</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give year and dates of service) <u>WW2</u> 16. SOCIAL SECURITY NO. <u>WVA</u> 17. INFORMANT <u>Mrs Ethel Castle, wife, 1013 FIFER Ave, Alexandria VA</u> Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X CORONARY Occlusion Acute</u> DUE TO (b) <u>AS CVD</u> DUE TO (c) <u>diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Interval BETWEEN ONSET AND DEATH 12 hours</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>F. J. Townsend Jr.</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <u>ASST</u> Address (Street, city, town, or county) <u>Aug 13, 1960</u>			22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>8/17/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT.</u> 22d. LOCATION (City, town, or country) (State) <u>ARLINGTON VA</u>		
23. FUNERAL DIRECTOR <u>Anna A. Burbyc Berlin Md</u> ADDRESS <u>Berlin Md</u> 24a. REC'D BY REGISTRAR <u>Aug 16 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

MEDICAL CERTIFICATION

44

9786

CERTIFICATE OF DEATH

09752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City c. LENGTH OF STAY IN 1b Pocomoke City d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 438 Bank Street		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS 438 Bank Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William B. Dickerson		4. DATE OF DEATH Month Day Year August 13 1960	
5. SEX Negro	6. COLOR OR RACE Male	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Dickerson		14. MOTHER'S MAIDEN NAME Henrietta Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-474	
17. INFORMANT Mrs. Wanda Matthews, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 11, 1960 , to Aug 13, 1960 , that I last saw the deceased alive on Aug 11, 1960 , and that death occurred at 9:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Aug 16, 1960			
ACTUAL SIGNATURE W. B. Cretcher		M.D.	
PHYSICIAN'S NAME (Type) Physician			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/16/60	22c. NAME OF CEMETERY OR CREMATORY Halls Hill Cem.	22d. LOCATION (City, town, or county) (State) Pocomoke City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Whorton - New Church, Va.		24a. REC'D BY REGISTRAR DATE AUG 19 1960	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

(N)

(1)

VR A1S (4)
15M 9/S9

09753

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHALEYVILLE		c. LENGTH OF STAY IN 1b BOYRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHALEYVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAURA ELLEN HALL				4. DATE OF DEATH Month AUG. Day 28 Year 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 25, 1880	
9. AGE (In years lost birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WILLARDS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GARRISON TRUITT				14. MOTHER'S MAIDEN NAME ELIZABETH BRADFORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MRS. BETTY ELISI, WHALEYVILLE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (Aden) of breast & colon (operated on Jan 18, 1960) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from March 1960 to day 7 death 19____, that (I) (we) last saw the deceased alive on 8-28 19 60 , and that death occurred at 7A M, from the causes and on the date stated above.							
22a. SIGNATURE Frank R. Lewis				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City, town, or county) (State) BERGLEY MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Barbey Berlin md.				ADDRESS Berlin md.		25a. REC'D BY REGISTRAR DATE SEP 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

1072

CERTIFICATE OF DEATH

1883



CHIEF OF POLICE

INVOICE

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09778

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>All his life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>		e. STREET ADDRESS <u>1. Berlin</u>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Hudson</u> Middle <u>Hudson</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/12/1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	9. AGE (In years last birthday) <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Roscoe Jones</u>		Address <u>Berlin, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>322.1</u> DUE TO <u>Chronic Alcoholism</u> Conditions, if any, which gave rise to immediate cause (b) <u>15 years</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lengthy exposures & improper diets</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius Sr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wynner Cemetery</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Therenton B. Jolley</u>		24a. REC'D BY REGISTRAR <u>Aug 9 '60</u>	
ADDRESS <u>Salisbury, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

DATE SIGNED

8/5/60

1

97779

CERTIFICATE OF DEATH

09755

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS MARYLAND AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELLA VIRGINIA JARVIS				4. DATE OF DEATH Month Day Year AUG. 27 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1880	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BERLIN MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE JONES				14. MOTHER'S MAIDEN NAME ELISIA HOLLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NO		17. INFORMANT MISS FLORENCE COFFIN, BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastases sec 8 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension w/ Kidney 3 years DUE TO (c) Anemia + Cachexia				INTERVAL BETWEEN ONSET AND DEATH 8 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of hip Apr 1960 - surgically healed							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 1947 to Aug 27 1960 , that (I) (we) last saw the deceased alive on Aug 27 1960 and that death occurred at 10 M, from the causes and on the date stated above.							
22a. SIGNATURE Kenneth A. Nathan				22b. DATE SIGNED 8/28/60		22c. PHYSICIAN'S NAME (Type) Amma A. Burby	
22d. ADDRESS Berlin, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/30/60		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City, town, or county) (State) BERLIN MD	
24. FUNERAL DIRECTOR'S SIGNATURE Amma A. Burby				25a. REC'D BY REGISTRAR SEP 1 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

100775

REPUBLIC OF CHINA

9710

Handwritten text, mostly illegible due to bleed-through from the reverse side. The text appears to be a letter or official document, possibly in Chinese or English, with some lines clearly visible such as "Dear Sir" and "Yours faithfully".

(1)

(1)



CERTIFICATE OF DEATH

Reg. Dist. No.

09756

9787

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 17 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belden Restorium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BLANCHE Middle J. Last MASON		4. DATE OF DEATH Month August Day 2 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months 84 Days 84 Hours 84 Min. 84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hudson Peter Hudson		14. MOTHER'S MAIDEN NAME Mary Landing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allen R. Mason, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Degenerative Heart Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1959 , to Aug 2, 1960 that I last saw the deceased alive on August 2, 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 302 Market St., Pocomoke City, Md. DATE SIGNED 8-3-60			
ACTUAL SIGNATURE Charles W. Trader		M.D. 302 Market St., Pocomoke City, Md.	
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-60	
22c. NAME OF CEMETERY Salem Methodist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR DATE AUG 8 '60		24b. REGISTRAR'S SIGNATURE Clinton S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Registrar	
10. Signature of Medical Officer		11. Signature of Coroner		12. Signature of Police Officer	
13. Signature of Family Member		14. Signature of Witness		15. Signature of Burial Officer	
16. Signature of Undertaker		17. Signature of Cemetery Officer		18. Signature of Burial Officer	
19. Signature of Burial Officer		20. Signature of Burial Officer		21. Signature of Burial Officer	
22. Signature of Burial Officer		23. Signature of Burial Officer		24. Signature of Burial Officer	
25. Signature of Burial Officer		26. Signature of Burial Officer		27. Signature of Burial Officer	
28. Signature of Burial Officer		29. Signature of Burial Officer		30. Signature of Burial Officer	
31. Signature of Burial Officer		32. Signature of Burial Officer		33. Signature of Burial Officer	
34. Signature of Burial Officer		35. Signature of Burial Officer		36. Signature of Burial Officer	
37. Signature of Burial Officer		38. Signature of Burial Officer		39. Signature of Burial Officer	
40. Signature of Burial Officer		41. Signature of Burial Officer		42. Signature of Burial Officer	
43. Signature of Burial Officer		44. Signature of Burial Officer		45. Signature of Burial Officer	
46. Signature of Burial Officer		47. Signature of Burial Officer		48. Signature of Burial Officer	
49. Signature of Burial Officer		50. Signature of Burial Officer		51. Signature of Burial Officer	
52. Signature of Burial Officer		53. Signature of Burial Officer		54. Signature of Burial Officer	
55. Signature of Burial Officer		56. Signature of Burial Officer		57. Signature of Burial Officer	
58. Signature of Burial Officer		59. Signature of Burial Officer		60. Signature of Burial Officer	
61. Signature of Burial Officer		62. Signature of Burial Officer		63. Signature of Burial Officer	
64. Signature of Burial Officer		65. Signature of Burial Officer		66. Signature of Burial Officer	
67. Signature of Burial Officer		68. Signature of Burial Officer		69. Signature of Burial Officer	
70. Signature of Burial Officer		71. Signature of Burial Officer		72. Signature of Burial Officer	
73. Signature of Burial Officer		74. Signature of Burial Officer		75. Signature of Burial Officer	
76. Signature of Burial Officer		77. Signature of Burial Officer		78. Signature of Burial Officer	
79. Signature of Burial Officer		80. Signature of Burial Officer		81. Signature of Burial Officer	
82. Signature of Burial Officer		83. Signature of Burial Officer		84. Signature of Burial Officer	
85. Signature of Burial Officer		86. Signature of Burial Officer		87. Signature of Burial Officer	
88. Signature of Burial Officer		89. Signature of Burial Officer		90. Signature of Burial Officer	
91. Signature of Burial Officer		92. Signature of Burial Officer		93. Signature of Burial Officer	
94. Signature of Burial Officer		95. Signature of Burial Officer		96. Signature of Burial Officer	
97. Signature of Burial Officer		98. Signature of Burial Officer		99. Signature of Burial Officer	
100. Signature of Burial Officer		101. Signature of Burial Officer		102. Signature of Burial Officer	

09757

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN b. <u>1-Day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>George Washington Hotel</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Colonel - Edgerton</u> <u>Merrill</u>		4. DATE OF DEATH Month Day Year <u>Aug</u> <u>21</u> <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/21/01</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Addressograph</u>	
13. FATHER'S NAME <u>Hamilton Wilcox Merrill</u>		14. MOTHER'S MAIDEN NAME <u>Winifred Edgerton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>1143 Cherry St. Winnetka, Illinois</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (a) <u>Pulmonary edema, acute massive</u> (b) <u>Dilatation rt. antrum & ventricle, acute</u> (c) <u>Arteriosclerosis, coronary with sub total occlusion</u>		17. INTERVAL BETWEEN ONSET AND DEATH <u>Deferred Pending Autopsy Report</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	23d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	23e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	23f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>		DATE SIGNED <u>Aug 21, 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 26, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery-Arlington, Virginia</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>Aug 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Walter S. Travis</u>	

1970-1971

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9790

09758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Virginia b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Church	
d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BETTIE COLLINS NELSON		4. DATE OF DEATH Month Day Year August 14 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1875
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Henry Collins		14. MOTHER'S MAIDEN NAME Leah Eleanor Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Leona M. Collins, Stockton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary (Probably) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) Anterior Myocardial Infarction (c) stating the underlying cause last. RHEUMATIC ARTERITIS + OBESITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE N. E. SARTORIUS, SR.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 8/14/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-60	
22c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		22d. LOCATION (City, town, or county) (State) Rural-New Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR DATE AUG 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death	
John William Jones		45		Male		White		April 14, 1955		10:30 PM		Home		Heart Disease	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Other Habits	
1234 Main Street, Baltimore, Md.		Teacher		High School		Married		Hypertension, Diabetes		Occasional		Daily		None	
Physician		Medical Examiner		Coroner		Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Dr. J. E. Thompson		J. E. Thompson		J. E. Thompson		St. John's Church, Baltimore, Md.		April 15, 1955		11:00 AM		St. John's Church, Baltimore, Md.		April 15, 1955	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b <u>Vacationing</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27 (apartment)</u> d. STREET ADDRESS <u>0351-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Emmis</u> Last <u>Pryor</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>1st</u> Year <u>1960</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8th 1919</u>		9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>00</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>Wachter D Pryor</u>						14. MOTHER'S MAIDEN NAME <u>Susan Pryor</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes World War 2 1942-45</u>						16. SOCIAL SECURITY NO. <u>217-09-104</u>						17. INFORMANT <u>Mr Burroughs</u> Address <u>Berlin, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Ocean bathing</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary disease</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deceased had another stroke 10 days before death</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>stroke</u>											
20c. TIME OF INJURY Month <u>8</u> Day <u>1</u> Year <u>1960</u> Hour <u>8</u> a. m. <u>15</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>beach</u>				20f. (City or town) <u>Ocean City</u> (County) <u>Worcester</u> (State) <u>Md</u>							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>N. E. Sartorius</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>8/3/60</u>					
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>				22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrice Inc.</u> ADDRESS <u>1328 Sulphur Spring Rd.</u>						24a. REC'D BY REGISTRAR <u>DATE AUG 8 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>							

TO DO: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09760

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Alabama</u> b. COUNTY <u>Surgey</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Self-governed Del Ray</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankford (RA) Del</u> d. STREET ADDRESS <u>46X-3</u>	
3. NAME OF DECEASED (Type or print) <u>Harbison Hickman Lullen</u>		4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9th 1924</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>16</u> Hours <u>10</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during 5 yrs. of working life, even if retired) <u> Sailor </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> Tug boat </u>	
11. BIRTHPLACE (State or foreign country) <u> Del </u>		12. CITIZEN OF WHAT COUNTRY? <u> U.S. </u>	
13. FATHER'S NAME <u> Henry Lullen </u>		14. MOTHER'S MAIDEN NAME <u> Rickards </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> No </u>		16. SOCIAL SECURITY NO. <u> 22-22-4025 </u>	
17. INFORMANT <u> Robert Walter Lullen </u> Address <u> Frankford Rd. </u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u> 420.1 </u> DUE TO <u> Coronary Occlusion </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> Sudden </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> Obesity - Heavy Smoker Tobacco </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> 19 </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u> R. E. Sartorius Sr. </u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u> R. E. Sartorius Sr. </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u> 8/28/60 </u>	
22c. NAME OF CEMETERY OR CREMATORY <u> Roxana Cemetery </u>		22d. LOCATION (City, town, or county) (State) <u> Roxana Del </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> Henry H. Watson </u> ADDRESS <u> Vicksburg Md. </u>		24a. REC'D BY REGISTRAR <u> AUG 29 60 </u> DATE	
24b. REGISTRAR'S SIGNATURE <u> Robert S. ... </u>		DATE SIGNED <u> 8/25/60 </u>	

TO DEATH CERTIFICATE, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8501

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Registrar		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Place		15. Signature of Cemetery		16. Signature of Funeral Home	
17. Signature of Mortician		18. Signature of Embalmer		19. Signature of Preparator		20. Signature of Assistant	
21. Signature of Assistant		22. Signature of Assistant		23. Signature of Assistant		24. Signature of Assistant	
25. Signature of Assistant		26. Signature of Assistant		27. Signature of Assistant		28. Signature of Assistant	
29. Signature of Assistant		30. Signature of Assistant		31. Signature of Assistant		32. Signature of Assistant	
33. Signature of Assistant		34. Signature of Assistant		35. Signature of Assistant		36. Signature of Assistant	
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41. Signature of Assistant		42. Signature of Assistant		43. Signature of Assistant		44. Signature of Assistant	
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49. Signature of Assistant		50. Signature of Assistant		51. Signature of Assistant		52. Signature of Assistant	
53. Signature of Assistant		54. Signature of Assistant		55. Signature of Assistant		56. Signature of Assistant	
57. Signature of Assistant		58. Signature of Assistant		59. Signature of Assistant		60. Signature of Assistant	
61. Signature of Assistant		62. Signature of Assistant		63. Signature of Assistant		64. Signature of Assistant	
65. Signature of Assistant		66. Signature of Assistant		67. Signature of Assistant		68. Signature of Assistant	
69. Signature of Assistant		70. Signature of Assistant		71. Signature of Assistant		72. Signature of Assistant	
73. Signature of Assistant		74. Signature of Assistant		75. Signature of Assistant		76. Signature of Assistant	
77. Signature of Assistant		78. Signature of Assistant		79. Signature of Assistant		80. Signature of Assistant	
81. Signature of Assistant		82. Signature of Assistant		83. Signature of Assistant		84. Signature of Assistant	
85. Signature of Assistant		86. Signature of Assistant		87. Signature of Assistant		88. Signature of Assistant	
89. Signature of Assistant		90. Signature of Assistant		91. Signature of Assistant		92. Signature of Assistant	
93. Signature of Assistant		94. Signature of Assistant		95. Signature of Assistant		96. Signature of Assistant	
97. Signature of Assistant		98. Signature of Assistant		99. Signature of Assistant		100. Signature of Assistant	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a death certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9783 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09761

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4 Somerset</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harold Edward Staley</u>		4. DATE OF DEATH <u>Aug 25 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14 1915</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Number</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Yellow Springs, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARIE Staley</u>		14. MOTHER'S MAIDEN NAME <u>LENORE Stone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>12000</u>	
17. INFORMANT <u>MRS Pauline Staley (wife)</u>		Address <u>R 7 Frederick</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY Occlusion Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY Artery Disease</u> DUE TO (c) <u>INSTANT</u> <u>3 years.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANCIS J TOWNSEND JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>Worcester Co.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pauline A. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	
DATE <u>AUG 30 '60</u>			

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9784 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09762

Items 5, 6 Film G269 8-17-60 at

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Wicomico ✓	
c. LENGTH OF STAY IN 1b 15 MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md 2212.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DAY AT WORCESTER ST		d. STREET ADDRESS 806 EAST Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Bly Last Wright		4. DATE OF DEATH Month Aug Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARY 1925
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Eden Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY FURNISS		14. MOTHER'S MAIDEN NAME Queen PARSONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Husband - HARRY M. WRIGHT		Address Salisbury Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Waded out in water - Fell in over heat - could not swim
20c. TIME OF INJURY Month, Day, Year Hour 9:45 a.m. Aug 5 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BAU
20f. (City or town) Ocean City		(County) Wor (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Francis J. Townsend		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANCIS J. TOWNSEND		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/1960	
22c. NAME OF CEMETERY OR CREMATORY Green acres		22d. LOCATION (City, town, or county) Salisbury Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart		ADDRESS Salisbury Md	
24a. REC'D BY REGISTRAR Aug 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

